

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF CALIFORNIA

-----oo0oo-----

PIERRE KORY, M.D., LE TRINH
HOANG, D.O., BRIAN TYSON, M.D.,
PHYSICIANS FOR INFORMED CONSENT,
a not-for-profit corporation,
and CHILDREN'S HEALTH DEFENSE, a
not-for-profit corporation,

Plaintiffs,

v.

ROB BONTA, in his official
capacity as Attorney General of
California, REJI VARGHESE, in
his official capacity as
Executive Director of the
Medical Board of California, and
ERIKA CALDERON, in her official
capacity as Executive Officer of
the Osteopathic Medical Board of
California,

Defendants.

No. 2:24-cv-00001 WBS AC

MEMORANDUM AND ORDER RE:
PLAINTIFFS' MOTION FOR
PRELIMINARY INJUNCTION

-----oo0oo-----

Plaintiffs Pierre Kory, Le Trinh Hoang, Brian Tyson,
Physicians for Informed Consent, and Children's Health Defense
brought this § 1983 action against defendants Rob Bonta, in his

1 official capacity as Attorney General of California, and Reji
2 Varghese and Erika Calderon, in their official capacity as
3 Executive Director and Executive Officer of the Medical Board of
4 California and the Osteopathic Medical Board of California,
5 respectively (the "Boards"). (Docket No. 1.) Plaintiffs Kory,
6 Hoang, and Tyson are physicians licensed by the Boards. The
7 remaining two plaintiffs are organizations representing the
8 interests of doctors and patients.

9 Plaintiffs challenge the constitutionality of the
10 Boards' powers to discipline physicians under Cal. Bus. & Prof.
11 Code § 2234 for conveying COVID-19-related information to their
12 patients.

13 I. Factual and Procedural Background

14 The court previously related this case to two cases
15 that challenged the constitutionality of California's Assembly
16 Bill ("AB") 2098: Høeg v. Newsom, 2:22-cv-1980 WBS AC, and Hoang
17 v. Bonta, 2:22-cv-2147 WBS AC. (Docket No. 5.)

18 AB 2098, then codified at Cal. Bus. & Prof. Code § 2270
19 but since repealed, took effect on January 1, 2023. The statute
20 provided that "[i]t shall constitute unprofessional conduct for a
21 physician and surgeon to disseminate misinformation . . . related
22 to COVID-19, including false or misleading information regarding
23 the nature and risks of the virus, its prevention and treatment;
24 and the development, safety, and effectiveness of COVID-19
25 vaccines." Cal. Bus. & Prof. Code § 2270(a) (repealed 2024).
26 The statute defined "misinformation" as "false information that
27 is contradicted by contemporary scientific consensus contrary to
28 the standard of care." Id. § 2270(b)(4). The statute augmented

1 the definition of “unprofessional conduct,” id. § 2270(a), which
2 is a pre-existing basis for disciplinary action by the Boards,
3 see id. § 2234.

4 This court preliminarily enjoined enforcement of AB
5 2098 against the Høeg and Hoang plaintiffs on January 25, 2023,
6 on the ground that the law was unconstitutionally vague under the
7 Fourteenth Amendment. See Høeg v. Newsom, 652 F. Supp. 3d 1172
8 (E.D. Cal. 2023).

9 The California Legislature subsequently repealed AB
10 2098, effective January 1, 2024. See Cal. Senate Bill 815 (Sept.
11 30, 2023). Both the Ninth Circuit and this court determined that
12 the repeal of AB 2098 mooted actions challenging the statute.
13 See McDonald v. Lawson, 94 F.4th 864, 870 (9th Cir. 2024); Høeg,
14 2024 WL 1406591, at *1-2 (E.D. Cal. Apr. 2, 2024). This court
15 therefore dismissed the Høeg and Hoang actions. See id. at *3.
16 Plaintiffs filed this action, making similar First Amendment
17 arguments to those raised (but not addressed by the court) in the
18 Høeg and Hoang matters. While the Høeg and Hoang matters
19 involved First and Fourteenth Amendment challenges to AB 2098,
20 the plaintiffs here bring a First Amendment challenge to the
21 Boards’ longstanding authority to discipline doctors under
22 Business & Professions Code § 2234.

23 Plaintiffs now move for a preliminary injunction.
24 (Docket No. 14.)

25 III. Preliminary Injunction Standard

26 To succeed on a motion for a preliminary injunction,
27 plaintiffs must establish that (1) they are likely to succeed on
28 the merits; (2) they are likely to suffer irreparable harm in the

1 absence of preliminary relief; (3) the balance of equities tips
2 in their favor; and (4) an injunction is in the public interest.
3 Winter v. Nat. Res. Def. Council, Inc., 555 U.S. 7, 20 (2008);
4 Perfect 10, Inc. v. Google, Inc., 653 F.3d 976, 979 (9th Cir.
5 2011). “[I]njunctive relief [i]s an extraordinary remedy that
6 may only be awarded upon a clear showing that the plaintiff is
7 entitled to such relief.” Winter, 555 U.S. at 22.

8 III. Discussion

9 A. Regulation of Physicians and the First Amendment

10 “[R]egulating the content of professionals’ speech
11 ‘pose[s] the inherent risk that the Government seeks not to
12 advance a legitimate regulatory goal, but to suppress unpopular
13 ideas or information.’” Nat’l Inst. of Fam. & Life Advoc. v.
14 Becerra, 585 U.S. 755, 771 (2018) (“NIFLA”) (quoting Turner
15 Broad. Sys., Inc. v. F.C.C., 512 U.S. 622, 641 (1994)).
16 “[P]hysician speech is entitled to First Amendment protection
17 because of the significance of the doctor-patient relationship.”
18 Conant v. Walters, 309 F.3d 629, 636 (9th Cir. 2002). Physicians
19 “must be able to speak frankly and openly to patients,” in part
20 because “barriers to full disclosure would impair diagnosis and
21 treatment.” Id.

22 However, under longstanding Supreme Court precedent,
23 “[s]tates may regulate professional conduct, even though that
24 conduct incidentally involves speech.” See NIFLA, 585 U.S. at
25 768; see also Sorrell v. IMS Health Inc., 564 U.S. 552, 567
26 (2011) (“the First Amendment does not prevent restrictions
27 directed at . . . conduct from imposing incidental burdens on
28 speech”); R.A.V. v. City of St. Paul, 505 U.S. 377, 389 (1992)

1 ("words can in some circumstances violate laws directed not
2 against speech but against conduct"). "[I]t has never been
3 deemed an abridgement of freedom of speech or press to make a
4 course of conduct illegal merely because the conduct was in part
5 initiated, evidenced, or carried out by means of language, either
6 spoken, written, or printed.'" Nat'l Ass'n for Advancement of
7 Psychoanalysis v. Cal. Bd. of Psych., 228 F.3d 1043, 1053 (9th
8 Cir. 2000) ("NAAP") (quoting Giboney v. Empire Storage & Ice Co.,
9 336 U.S. 490, 502 (1949)).

10 Physician conduct is no exception to this rule.
11 Accordingly, the Supreme Court has explained that there is "no
12 constitutional infirmity" where a law "implicate[s]" a
13 physician's First Amendment rights "only as part of the practice
14 of medicine, [which is] subject to reasonable licensing and
15 regulation by the State." See Planned Parenthood of Se. Pa. v.
16 Casey, 505 U.S. 833, 884 (1992), overruled on other grounds by
17 Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022) (cited
18 with approval in NIFLA, 585 U.S. at 769-70). "When a drug is
19 banned, for example, a doctor who treats patients with that drug
20 does not have a First Amendment right to speak the words
21 necessary to provide or administer the banned drug." Pickup v.
22 Brown, 740 F.3d 1208, 1229 (9th Cir. 2014), abrogated on other
23 grounds by NIFLA, 585 U.S. 755. Indeed, "[m]ost, if not all,
24 medical . . . treatments require speech, but that fact does not
25 give rise to a First Amendment claim." Id.; see also Robert
26 Post, Informed Consent to Abortion: A First Amendment Analysis of
27 Compelled Physician Speech, 2007 U. Ill. L. Rev. 939, 950 (2007)
28 ("The practice of medicine, like all human behavior, transpires

1 through the medium of speech. In regulating the practice,
2 therefore, the state must necessarily also regulate" the speech
3 of physicians.).

4 1. Overview of Recent Cases

5 In Pickup, the Ninth Circuit analyzed the speech-
6 conduct distinction in a case challenging Washington's law
7 banning the practice of sexual orientation conversation therapy
8 on children. The court stated that laws regulating the speech of
9 health care professionals could be placed along a "continuum."
10 See 740 F.3d at 1227. "At one end of the continuum, where a
11 professional is engaged in a public dialogue, First Amendment
12 protection is at its greatest." Id. "At the other end of the
13 continuum . . . is the regulation of professional conduct, where
14 the state's power is great, even though such regulation may have
15 an incidental effect on speech." Id. at 1229 (emphasis added).

16 "At the midpoint of the continuum, within the confines
17 of a professional relationship, First Amendment protection of a
18 professional's speech is somewhat diminished." Id. at 1228. As
19 such, the Ninth Circuit explained, in that midpoint category of
20 "professional speech," "the First Amendment tolerates a
21 substantial amount of speech regulation within the professional-
22 client relationship that it would not tolerate outside of it."
23 See id. at 1229.

24 Applying these principles to the Washington law, the
25 Pickup court concluded that the challenged law fell at the
26 "conduct" end of the spectrum because it regulated a "form of
27 treatment" and "[did] nothing to prevent licensed therapists from
28 discussed the pros and cons of [conversion therapy] with their

1 patients.” See id. That “speech may be used to carry out”
2 conversion therapy “[did] not turn the regulation of conduct into
3 a regulation of speech.” Id.

4 Four years later, in NIFLA, the Supreme Court
5 considered a California law requiring so-called “crisis pregnancy
6 centers” to make certain compelled disclosures. See 585 U.S. at
7 763-64. In analyzing the constitutionality of the law, the NIFLA
8 court explicitly rejected Pickup’s continuum approach and
9 delineation of “‘professional speech’ as a separate category of
10 speech that is subject to different rules.” See id. at 767. The
11 Court stated that its “precedents do not recognize [a tradition
12 of allowing content-based restrictions] for a category called
13 ‘professional speech,’” but reiterated the longstanding rule --
14 relied upon by the Pickup court -- that “States may regulate
15 professional conduct, even though that conduct incidentally
16 involves speech.” See id. at 768.

17 In Tingley v. Ferguson, 47 F.4th 1055 (9th Cir. 2022),
18 cert. denied, 144 S. Ct. 33 (2023), the Ninth Circuit considered
19 a challenge to a California law banning conversion therapy that
20 was functionally identical to the one considered in Pickup. The
21 case gave the Ninth Circuit occasion to consider what effect
22 NIFLA had on Pickup. The court concluded that “NIFLA abrogated
23 only the ‘professional speech’ doctrine -- the part of Pickup in
24 which we determined that speech within the confines of a
25 professional relationship” (the “theoretical ‘midpoint’ of the
26 continuum”) receives decreased scrutiny. See id. at 1073, 1075.

27 However, the Tingley court determined that “the
28 conduct-versus-speech distinction from Pickup remains intact”

1 post-NIFLA. See id. at 1055. NIFLA therefore did not abrogate
2 Pickup's analysis of the Washington conversion therapy law, which
3 fell within the category of professional conduct. See id. at
4 1077.

5 Following NIFLA and Tingley, then, a court's task in
6 analyzing a regulation of physicians under the First Amendment is
7 to determine whether the law at issue regulates physician speech,
8 in which case it is subject to strict scrutiny; or regulates
9 physician conduct, in which case it is not constitutionally
10 suspect and subject to rational basis review. See NIFLA, 585
11 U.S. at 767; Tingley, 47 F.4th at 1072, 1078.

12 2. Physician Conduct Versus Physician Speech

13 As a representative example, Dr. Kory avers that he
14 provides consultations during which he addresses patient
15 "questions and concerns" about ivermectin for the treatment of
16 COVID-19, including "whether he recommends its use." (Verified
17 Compl. (Docket No. 9) ¶ 19.)¹ Relying on Conant, plaintiffs
18 argue that this type of consultation is protected physician
19 speech.

20 In Conant, the Ninth Circuit addressed the
21 constitutionality of a federal policy of "investigating doctors
22 or initiating proceedings against doctors only because they
23 'recommend' the use of marijuana." 309 F.3d at 634. This policy
24 was grounded in marijuana's classification as a controlled
25 substance, which barred doctors from prescribing marijuana in any
26

27 ¹ While plaintiffs make numerous contentions concerning
28 the efficacy of ivermectin in treating COVID-19, the court's task
here is not to determine the legitimacy of any medical treatment.

1 circumstance. See id. at 632-34. The Ninth Circuit concluded
2 that the policy violated the First Amendment because it
3 “punish[ed] physicians on the basis of the content of doctor-
4 patient communications.” See id. at 637.

5 In coming to this conclusion, the Ninth Circuit pointed
6 out the distinction between a “recommendation” untethered from
7 treatment of a patient, and a “recommendation [that] the
8 physician intends for the patient to use . . . as the means for
9 obtaining marijuana.” See id. at 635. The former is speech,
10 while the latter is regulable conduct -- akin to a doctor’s
11 “prescription” of a drug -- that could lead to criminal liability
12 for aiding and abetting the patient’s violation of federal law.
13 See id. at 635-36. As the Pickup court explained, Conant
14 indicates that “doctor-patient communications about medical
15 treatment receive substantial First Amendment protection, [while]
16 the government has more leeway to regulate the conduct necessary
17 to administering treatment itself.” See 740 F.3d at 1227.

18 It was not, as plaintiffs seem to suggest, the use of
19 the word “recommendation” that was dispositive in Conant. If
20 that were the case, doctors could frame their treatment as
21 “recommendations” to shield themselves from regulation. Instead,
22 it was the relationship of the doctors’ marijuana recommendation
23 to treatment that mattered. See Conant, 309 F.3d at 635-36;
24 Pickup, 740 F.3d at 1227; see also Rumsfeld v. F. for Acad. and
25 Inst. Rights, Inc., 547 U.S. 47, 66 (2006) (“If combining speech
26 and conduct were enough to create expressive conduct, a regulated
27 party could always transform conduct into ‘speech’ simply by
28 talking about it.”).

1 It is important to note the specific context presented
2 by Conant where, by legal necessity, any physician's
3 "recommendation" of marijuana was entirely disconnected from the
4 physician's treatment of the patients. This is because to treat
5 a patient with marijuana was illegal and would have subjected the
6 physician to criminal liability (which the parties agreed was not
7 constitutionally problematic). See 309 F.3d at 634-35; see also
8 Pickup, 740 F.3d at 1229 (explaining that the policy at issue in
9 Conant "prohibited speech wholly apart from the actual provision
10 of treatment") (emphasis in original). Thus, in Conant, it was
11 simple for the Ninth Circuit to create a clear "demarcation
12 between conduct and speech." See Pickup, 740 F.3d at 1226
13 (citing Conant, 309 F.3d at 632, 635-36); see also Conant, 309
14 F.3d at 635 (indicating that the injunction upheld on review drew
15 a "clear line between protected medical speech and illegal
16 conduct").

17 Most situations in medical practice are not so clear-
18 cut. Within the same patient conversation, a doctor could go
19 from (1) speaking about his views on a particular treatment based
20 on his experience and expertise, to (2) prescribing the use of
21 that treatment for the patient's care. The former would be
22 speech, while the latter would be conduct. This is because the
23 "key component" of a doctor's prescription of a drug is the
24 provision of the drug, not the speech itself. See NAAP, 228 F.3d
25 at 1054. And "the First Amendment does not prevent a state from
26 regulating treatment even when that treatment is performed
27 through speech alone." Pickup, 740 F.3d at 1230. Thus, when a
28 doctor speaks in his capacity as the patient's treating physician

1 and incident to his provision of medical care, the physician's
2 words constitute regulable conduct.

3 Returning to the situation posed by Dr. Kory, his
4 discussion with a patient of the "pros and cons" of ivermectin
5 and a statement that he generally recommends the use of that
6 treatment for COVID-19 could be considered speech. See Conant,
7 309 F.3d at 634; see also Pickup, 740 F.3d at 1229 (law banning
8 conversion therapy was constitutional in part because it
9 "allow[ed] discussions about treatment, recommendations to obtain
10 treatment, and expressions of opinions about" treatment). If Dr.
11 Kory were to prescribe the medication, instruct the patient to
12 take the medication, or otherwise use words to treat the patient
13 -- for example by saying, "I recommend that you take 10
14 milligrams of ivermectin once a day for seven days" -- Dr. Kory's
15 words could constitute conduct regulable by the state, as his
16 speech was incident to his treatment of the patient.² Cf.
17 Conant, 309 F.3d at 635-36 (indicating that when a "physician
18 intends for the patient to use [his recommendation] as the means
19 for obtaining" an illegal drug, the recommendation of the drug
20 can be considered criminal conduct).

21 The court recognizes that the distinction between
22 physician speech and conduct may be subtle at times.
23 Nonetheless, "[w]hile drawing the line between speech and conduct
24 can be difficult, [the Supreme Court's] precedents have long

25
26 ² The court again emphasizes that it takes no position on
27 the propriety of using ivermectin to treat COVID-19. It only
28 concludes that, in the example raised by plaintiffs, treating a
patient with ivermectin falls within the bounds of "conduct" that
the state may permissibly regulate.

1 drawn it.” NIFLA, 585 U.S. at 769.

2 B. Section 2234(c) Is a Facially Constitutional Regulation
3 of Physician Conduct

4 California Business & Professions Code § 2234 grants
5 the Boards authority to “take action against any licensee who is
6 charged with unprofessional conduct.” Unprofessional conduct
7 includes, but is not limited to, incompetence, gross negligence,
8 and repeated negligent acts. Id. Plaintiffs seek to enjoin
9 enforcement of section 2234(c) pertaining to “repeated negligent
10 acts,” which are defined as “[a]n initial negligent act or
11 omission followed by a separate and distinct departure from the
12 applicable standard of care.” Id. § 2234(c).³ Plaintiffs argue
13 that the Boards will impermissibly use section 2234(c) to
14 discipline physicians for constitutionally protected doctor-
15 patient communications concerning COVID-19.

16 The statute is neutral on its face and applies broadly
17 to the practice of medicine by all doctors. It does not
18 discriminate between different types of content or speakers and
19 is therefore not a content-based regulation requiring the
20 application of strict scrutiny. See NIFLA, 585 U.S. at 766
21 (content-based regulations are those that “target speech based on
22 its communicative content”); see also NAAP, 228 F.3d at 1055

23
24 ³ Plaintiffs state that they seek to enjoin the entirety
25 of section 2234. However, their arguments appear only to address
26 section 2234(c), and plaintiffs’ counsel admits that he “has not
27 identified any other provision of the Business and Professions
28 Code which could be utilized by the board as an alternative”
basis for discipline. (See Docket No. 18 at 10.) The court
therefore construes plaintiffs’ motion as a challenge to section
2234(c).

1 ("California's [psychoanalyst] licensing scheme is content and
2 viewpoint neutral; therefore, it does not trigger strict
3 scrutiny.").

4 Further, the plain language of the statute -- which
5 uses the terms "unprofessional conduct" and "act or omission" --
6 clearly contemplates disciplinary action for conduct, not speech.
7 The statute's reference to the standard of care makes this plain
8 as, by its very nature, the standard of care applies to care, not
9 speech. See Alef v. Alta Bates Hosp., 5 Cal. App. 4th 208, 215
10 (1st Dist. 1992) (the standard of care determines "the minimum
11 level of care to which the patient is entitled") (emphasis
12 added). The statute is therefore a regulation of professional
13 conduct with only an incidental effect on speech, if any. See
14 NIFLA, 585 U.S. at 768; Casey, 505 U.S. at 884.

15 Because section 2234(c) regulates conduct, it need only
16 satisfy rational basis review. See Tingley, 47 F.4th at 1078.
17 Under this standard, a law need only be "rationally related to a
18 legitimate state interest" to pass constitutional muster. See
19 id. Section 2234(c) easily satisfies that standard.

20 A state has "a 'compelling interest in the practice of
21 professions within [its] boundaries.'" Tingley, 47 F.4th at 1078
22 (quoting Goldfarb v. Va. State Bar, 421 U.S. 773, 792 (1975)). A
23 state also has an interest in regulating health care providers to
24 protect patient health and safety. See Gonzales v. Carhart, 550
25 U.S. 124, 166 (2007); NAAP, 228 F.3d at 1054. The requirement
26 that doctors provide appropriate care is plainly related to
27 advancing those interests.

28 Indeed, as the Supreme Court has explained:

1 It is elemental that a state has broad power to establish
2 and enforce standards of conduct within its borders relative
3 to the health of everyone there. It is a vital part of a
4 state's police power. The state's discretion in that field
5 extends naturally to the regulation of all professions
6 concerned with health It is equally clear that a
7 state's legitimate concern for maintaining high standards of
8 professional conduct extends beyond initial licensing.
9 Without continuing supervision, initial examinations afford
10 little protection.

11 Barsky v. Bd. of Regents of Univ. of State of N.Y., 347 U.S. 442,
12 451 (1954). Accordingly, state "health and welfare laws" are
13 "entitled to a 'strong presumption of validity.'" See Dobbs, 597
14 U.S. at 301 (quoting Heller v. Doe, 509 U.S. 312, 319 (1993));
15 see also Conant, 309 F.3d at 639 (federal courts should respect
16 the "principles of federalism that have left states as the
17 primary regulators of [health professionals'] conduct"); NAAP,
18 228 F.3d at 1054 (citing Watson v. Maryland, 218 U.S. 173, 176
19 (1910)) ("It is properly within the state's police power to
20 regulate and license professions, especially when public health
21 concerns are affected.").

22 For the foregoing reasons, the court concludes that
23 section 2234(c) is a facially constitutional regulation of
24 physician conduct.

25 C. Plaintiffs' Have Not Established Standing to Bring an
26 As-Applied Challenge to Board Enforcement

27 Because section 2234(c) is a regulation of physician
28 conduct, Board discipline of protected speech would be, by
definition, outside the scope of 2234(c). To obtain an
injunction, plaintiffs would therefore need to mount an as-
applied challenge to some policy or practice of disciplining
physician speech by the Boards. However, plaintiffs have failed

1 to establish standing to challenge any such policy or practice.⁴

2 Article III standing has three elements: "(1) injury-
3 in-fact -- plaintiff must allege concrete and particularized and
4 actual or imminent harm to a legally protected interest; (2)
5 causal connection -- the injury must be fairly traceable to the
6 conduct complained of; and (3) redressability -- a favorable
7 decision must be likely to redress the injury-in-fact." Barnum
8 Timber Co. v. U.S. EPA, 633 F.3d 894, 897 (9th Cir. 2011) (citing
9 Lujan v. Defs. of Wildlife, 504 U.S. 555, 560 (1992)) (internal
10 quotation marks omitted).

11 "[A] plaintiff satisfies the injury-in-fact requirement
12 where he alleges 'an intention to engage in a course of conduct
13 arguably affected with a constitutional interest, but proscribed
14 by a statute, and there exists a credible threat of prosecution
15 thereunder.'" Susan B. Anthony List v. Driehaus, 573 U.S. 149,
16 159 (2014) (quoting Babbitt v. United Farm Workers Nat'l Union,
17 442 U.S. 289, 298 (1979)). The Ninth Circuit applies a "three-
18 factor inquiry to help determine whether a threat of enforcement
19 is genuine enough to confer an Article III injury": "(1) whether
20 the plaintiff has a 'concrete plan' to violate the law, (2)
21 whether the enforcement authorities have 'communicated a specific
22 warning or threat to initiate proceedings,' and (3) whether there
23 is a 'history of past prosecution or enforcement.'" Tingley, 47
24 F.4th at 1067 (quoting Thomas v. Anchorage Equal Rts. Comm'n, 220
25 F.3d 1134, 1139 (9th Cir. 2000) (en banc)). "Neither the mere

26 ⁴ Although defendants did not expressly argue that
27 plaintiffs lack standing, the court nonetheless has a duty to
28 evaluate Article III standing. See Bernhardt v. County of Los
Angeles, 279 F.3d 862, 868 (9th Cir. 2002).

1 existence of a proscriptive statute nor a generalized threat of
2 prosecution' satisfies this test." Id. (quoting Thomas, 220 F.3d
3 at 1139).

4 Challenges that involve First Amendment rights "present
5 unique standing considerations" because of the "chilling effect
6 of sweeping restrictions" on speech. Ariz. Right to Life Pol.
7 Action Comm. v. Bayless, 320 F.3d 1002, 1006 (9th Cir. 2003).
8 "In order to avoid this chilling effect, the Supreme Court has
9 endorsed what might be called a 'hold your tongue and challenge
10 now' approach rather than requiring litigants to speak first and
11 take their chances with the consequences." Italian Colors Rest.
12 v. Becerra, 878 F.3d 1165, 1171 (9th Cir. 2018) (internal
13 quotation marks omitted). Accordingly, when the challenged law
14 "implicates First Amendment rights, the [standing] inquiry tilts
15 dramatically toward a finding of standing." LSO, Ltd. v. Stroh,
16 205 F.3d 1146, 1155 (9th Cir. 2000).

17 Nonetheless, a plaintiff challenging a law on First
18 Amendment grounds must still demonstrate that "there exists a
19 credible threat of prosecution thereunder." See Susan B. Anthony
20 List, 573 U.S. at 159; see also Italian Colors Rest., 878 F.3d at
21 1171 ("Even in the First Amendment context, a plaintiff must show
22 a credible threat of enforcement.").

23 Plaintiffs have failed to make the necessary showing,
24 as the record is utterly devoid of any evidence that the Boards
25 have or may use their authority under section 2234(c) to do
26 anything other than regulate physician conduct, let alone
27 discipline physicians for their protected speech in the manner
28 plaintiffs suggest.

1 1. Threat of Enforcement

2 To show that authorities have communicated a threat of
3 enforcement, plaintiffs point to a statement allegedly made by
4 Assemblyman Evan Low (a sponsor of AB 2098) following the repeal
5 of AB 2098. Low purportedly stated that, despite the law's
6 repeal, "the Medical Board of California will continue to
7 maintain the authority to hold medical licensees accountable for
8 deviating from the standard of care and misinforming their
9 patients about COVID-19 treatments." (See Verified Compl. ¶ 73.)
10 Assuming that Mr. Low, in fact, made that statement (which
11 plaintiffs have not established)⁵, it provides no support for
12 plaintiffs' argument. Mr. Low is not a defendant in this action.
13 And the pronouncement of a politician, without more, does not
14 indicate that the Boards -- administrative agencies that operate
15 independently of the California Legislature -- will apply the law
16 in any particular way. See Dist. of Columbia v. Heller, 554 U.S.
17 570, 605 (2008) (explaining that so-called "postenactment
18 legislative history" is not legislative history at all and is not
19 a proper interpretive tool); Graham Cnty. Soil & Water
20 Conservation Dist. v. U.S. ex rel. Wilson, 559 U.S. 280, 297
21 (2010) ("a single sentence by a single legislator" is not

22 ⁵ The statement was provided by plaintiffs only in the
23 form of an unsupported allegation. (See Verified Compl. ¶ 73.)
24 However, the court was able to locate a Los Angeles Times article
25 containing the quote from Assemblyman Low. See Corinne Purtill,
26 Controversial law punishing doctors who spread COVID
27 misinformation on track to be undone, Los Angeles Times (Sept.
28 11, 2023). The court takes judicial notice of the fact that said
quote was attributed to Mr. Low "in the public realm at the time"
but expresses no opinion about "whether the contents of th[e]
article[] were in fact true." See Von Saher v. Norton Simon
Museum of Art at Pasadena, 592 F.3d 954, 960 (9th Cir. 2010).

1 "entitled to any meaningful weight"); Chem. Producers & Distribs.
2 Ass'n v. Helliker, 463 F.3d 871, 879 (9th Cir. 2006), overruled
3 on other grounds by Bd. of Trs. of Glazing Health & Welfare Tr.
4 v. Chambers, 941 F.3d 1195 (9th Cir. 2019) ("Attributing the
5 actions of a legislature to third parties rather than to the
6 legislature itself is of dubious legitimacy, and the cases
7 uniformly decline to do so."); X-Men Sec., Inc. v. Pataki, 196
8 F.3d 56, 69 (2d Cir. 1999) (the actions of legislators who
9 "cajole" and "exhort" agencies concerning administration of a
10 statute are "political rather than legislative in nature");
11 Goolsby v. Blumenthal, 581 F.2d 455, 460 (5th Cir. 1978), on
12 reh'g, 590 F.2d 1369 (5th Cir. 1979) (quoting Reg'l Rail Reorg.
13 Act Cases, 419 U.S. 102, 132 (1974)) ("post-passage remarks of
14 legislators . . . 'represent only the personal views of these
15 legislators'").

16 To establish a history of prior enforcement, plaintiffs
17 point to the alleged Board discipline of a physician who is not a
18 plaintiff in this action, Dr. Ana Reyna, for her provision of
19 certain COVID-19-related information and opinions. However,
20 plaintiffs provide nothing more than bare, unverified allegations
21 concerning the basis for Dr. Reyna's Board discipline. (See
22 Verified Compl. ¶¶ 21, 74.) The only evidence before the court
23 concerning Dr. Reyna shows that she surrendered her license
24 following the commencement of disciplinary proceedings. (See
25 id.) Because plaintiffs have not provided (and the court was
26 unable to locate) evidence regarding the basis for the
27 disciplinary action, the court disregards these allegations.

28 Finally, plaintiffs rely on the administrative and

1 legislative history related to AB 2098 to demonstrate that their
 2 desired speech concerning COVID-19 is proscribed by Board policy.
 3 But this case pertains to section 2234, not the now-repealed AB
 4 2098. Plaintiffs have provided no evidence that the Boards have
 5 or will treat the repeal of AB 2098 -- along with this court's
 6 preliminary injunction order and the Ninth Circuit panel's
 7 skepticism of the law during oral argument on the McDonald
 8 appeal⁶ -- as anything other than a mandate to refrain from
 9 improper regulation of doctors' speech. See Rosebrock v. Mathis,
 10 745 F.3d 963, 971 (9th Cir. 2014) ("We presume that a government
 11 entity is acting in good faith when it changes its policy.").
 12 Indeed, defendant Varghese stated in his capacity as Executive
 13 Director of the Medical Board that, following the passage of the
 14 repeal bill, AB 2098 would not be enforced even while it was
 15 still in effect. See McDonald, 94 F.4th at 869.

16 Accordingly, the court concludes that plaintiffs have
 17 failed to establish that there is any threat the Boards will
 18 enforce section 2234(c) or otherwise discipline physicians in a
 19 manner that implicates their protected speech.

20 2. COVID-19 and the Standard of Care

21 Plaintiffs additionally argue that they face a risk of
 22 discipline for any care provided to treat COVID-19 because "there
 23 is no legitimate [COVID-19] standard of care." (See Docket No.
 24 14 at 13.) In support of that argument, they cite the
 25 declaration they relied upon in Hoang v. Bonta (see Hoang Docket
 26

27 ⁶ See Oral Argument at 18:16 - 31:00, McDonald v. Lawson,
 28 94 F.4th 864, No. 22-56220 (9th Cir. 2023),
<https://www.ca9.uscourts.gov/media/video/?20230717/22-56220/>.

1 No. 4-2) and a declaration filed in this matter providing
2 additional information and scientific updates (see Kory Docket
3 No. 14-1). The declarations, authored by Dr. Sanjay Verma and
4 not objected to by defendants, explain the various ways in which
5 the scientific evidence on COVID-19 has changed over time and
6 remains contested. They also explain several ways in which the
7 pronouncements of public health authorities concerning COVID-19
8 have vacillated, at times to the point of either inconsistency
9 with scientific evidence or direct contradiction of prior
10 recommendations.

11 For example, Dr. Verma points out that at the beginning
12 of the pandemic, the CDC represented that cloth masks prevented
13 COVID-19 transmission and recommended their use among the general
14 population. (See Hoang Decl. ¶¶ 13-18; Appendix 1 to Hoang
15 Decl.) Later, scientific studies showed that cloth masks were
16 not effective at preventing the spread of COVID-19, and the CDC
17 eventually changed its recommendation concerning their use. (See
18 id.) As another example, Dr. Verma avers that the CDC continues
19 to recommend that the general population keep “up to date” on
20 COVID-19 vaccines and boosters, despite studies showing dwindling
21 vaccine efficacy and the potential for serious side effects.
22 (See Kory Decl. ¶¶ 39-46.) From such changes, disagreement, and
23 inconsistencies, plaintiffs make the logical leap that there is
24 no standard of care for COVID-19 treatment, placing them at risk
25 of discipline for all COVID-19-related care.

26 The court can understand plaintiffs’ frustration over
27 the various discrepancies and shifts in recommendations
28 concerning COVID-19. And the inconsistencies apparent in many of

1 those recommendations unfortunately do not reflect well on the
2 credibility of those who made them. However, it simply does not
3 follow that there is no standard of care applicable to COVID-19.
4 It cannot be the case that scientific disagreement and
5 inconsistencies in public health recommendations exempt doctors
6 from the requirement that they adhere to the standard of care.

7 The standard of care is a well-established legal
8 concept, "requir[ing] that medical service providers exercise
9 that degree of skill, knowledge and care ordinarily possessed and
10 exercised by members of their profession under similar
11 circumstances." See Barris v. County of Los Angeles, 20 Cal. 4th
12 101, 108 (1999). As defendants point out, this standard, in one
13 formulation or another, has governed the practice of medicine for
14 centuries. See Robert I. Field, The Malpractice Crisis Turns
15 175: What Lessons Does History Hold for Reform?, 4 Drexel L. Rev.
16 7, 10 (2011) ("[t]he earliest lawsuits for medical mistakes date
17 back several centuries to the formative stages of the common
18 law," with the "first reported case . . . decided in 1374"); see
19 also Arnett v. Dal Cielo, 14 Cal. 4th 4, 7 (1996) ("[s]ince the
20 earliest days of regulation," the California medical boards "have
21 been charged with the duty to protect the public against
22 incompetent, impaired, or negligent physicians"). The
23 application of a professional standard of practice is hardly
24 unique to the healthcare context. See, e.g., Gunn v. Minton, 568
25 U.S. 251, 264 (2013) (indicating that states have "a special
26 responsibility for maintaining standards among members of the
27 licensed professions," including through the imposition of
28 standards of practice for lawyers) (internal quotation marks and

1 citations omitted).

2 “The standard of care against which the acts of a
3 physician are to be measured is a matter peculiarly within the
4 knowledge of experts; it . . . can only be proved by their
5 testimony, unless the conduct required by the particular
6 circumstances is within the common knowledge of the layman.”
7 Flowers v. Torrance Mem’l Hosp. Med. Ctr., 8 Cal. 4th 992, 1001
8 (1994). (See also Calderon Decl. (Docket No. 17-1) ¶¶ 6-7,
9 Varghese Decl. (Docket No. 17-2) ¶¶ 5-6 (explaining that when the
10 Boards investigate a physician, a “medical consultant . . .
11 examines the medical record and any additional evidence to
12 determine whether there is a potential violation of the standard
13 of care,” in which case the matter is subject to further review
14 by a “retained outside medical expert”). Importantly, because
15 determination of the appropriate standard of care “is inherently
16 situational, the amount of care deemed reasonable in any
17 particular case will vary.” Flowers, 8 Cal. 4th at 997 (emphasis
18 added). No court could make a broad pronouncement about the
19 standard(s) of care applicable to an entire disease -- which can
20 present a vast range of clinical presentations and possible
21 treatment options -- let alone conclude that no such standard
22 exists.

23 That the standard of care remains in force in the
24 COVID-19 context is supported by common sense. Although there
25 may be areas of uncertainty when it comes to COVID-19, there are
26 nonetheless types of treatment that are clearly not permissible.
27 As a purely hypothetical example, if a doctor were to order a
28 patient under his care to drink a gallon of industrial rat poison

1 to treat COVID-19, no one could argue that would be consistent
2 with the standard of care. To conclude otherwise would interfere
3 with the State's appropriate exercise of its authority to ensure
4 that patients are protected from "charlatan[s]" masquerading as
5 professionals. See Pickup, 740 F.3d at 1228.

6 Seeking to brush aside the centuries-long regulation of
7 the medical profession, plaintiffs seem to conflate the standard
8 of care with the vague notion of "scientific consensus." Their
9 argument is premised on this court's prior finding that COVID-19
10 was "a quickly evolving area of science that in many aspects
11 eludes consensus," and therefore the term "scientific consensus"
12 was unconstitutionally vague. See Høeg, 652 F. Supp. 3d at 1188.
13 While the concept of a "consensus" among the medical community
14 may be related to the standard of care, the terms are not
15 interchangeable. And as indicated above, plaintiffs have not
16 offered any evidence that, following the repeal of AB 2098, the
17 Boards will discipline doctors in a manner that conflates the
18 two.

19 Plaintiffs also appear to treat the standard of care as
20 a rigid benchmark that cannot countenance reasonable medical
21 disagreement. To the contrary, the standard of care can and does
22 account for differing views among medical professionals. See
23 McAlpine v. Norman, 51 Cal. App. 5th 933, 938-39 (3d Dist. 2020)
24 (indicating that the standard of care in a medical malpractice
25 action is routinely determined based on "competing expert
26 testimony"); Blackwell v. Hurst, 46 Cal. App. 4th 939, 944 (2d
27 Dist. 1996) ("a difference of medical opinion concerning the
28 desirability of a particular medical procedure when several are

1 available does not establish that the one used was negligent");
2 Glover v. Bd. of Med. Quality Assurance, 231 Cal. App. 3d 203,
3 208 (1st Dist. 1991) ("As long as the differences of opinion [on
4 the standard of care] are legitimate, we have no dispute with the
5 notion that different methods of treatment can all be considered
6 acceptable medical practice."); Fraijo v. Hartland Hosp., 99 Cal.
7 App. 3d 331, 343 (2d Dist. 1979) (a physician's "error in medical
8 judgment" in selecting among treatment options is not
9 automatically considered negligent, but rather is "weighed in
10 terms of the professional standard of care"); Gearhart v. United
11 States, No. 15-cv-665 MDD, 2016 WL 3251972, at *9 (S.D. Cal. June
12 14, 2016) ("Under California law, a mere difference of medical
13 opinion is insufficient evidence to support a finding of
14 negligence.").

15 "Professionals might have a host of good-faith
16 disagreements, both with each other and with the government, on
17 many topics in their respective fields." NIFLA, 585 U.S. at 772.
18 "Only rarely does the physician enjoy true certainty regarding
19 any issue." 1 Am. Law Med. Malp. § 3:8. Disagreement between
20 competent medical professionals on the best course of treatment
21 for a given condition is common, and there is not necessarily any
22 violation of the standard of care in those circumstances. See
23 id. § 3:3 ("Within certain clinical settings, there may be
24 reasonably applicable alternative methods of diagnosis or
25 treatment. A physician choosing one or the other method would
26 not violate a 'standard' of good medical practice."); see also
27 Philip G. Peters, Jr., Doctors & Juries, 105 Mich. L. Rev. 1453,
28 1477 (2007) ("when researchers ask physicians to rate the quality

1 of care provided by other physicians, the participants disagree
2 among themselves" at a "surprisingly high" rate, as "[r]easonable
3 professionals often reach different conclusions about the same
4 evidence"); Peter D. Jacobson & Stefanie A. Doebler, "We Were All
5 Sold A Bill of Goods:" Litigating the Science of Breast Cancer
6 Treatment, 52 Wayne L. Rev. 43, 79 (2006) (in evaluating whether
7 a novel treatment option comports with the standard of care, part
8 of a court's task is to determine "when the widespread
9 disagreement among qualified medical experts over whether the
10 treatment or procedure at issue has crossed the line from being
11 an experimental procedure to become an acceptable medical
12 practice"); James Ducharme, Clinical Guidelines and Policies: Can
13 They Improve Emergency Department Pain Management?, 33 J.L. Med.
14 & Ethics 783, 786 (2005) ("If there is more than one recognized
15 course of treatment, most courts will allow some flexibility in
16 what is regarded as customary."); Joan P. Dailey, The Two Schools
17 of Thought and Informed Consent Doctrines in Pennsylvania: A
18 Model for Integration, 98 Dick. L. Rev. 713, 714 (1994) ("Courts
19 have long recognized that medicine is not an exact science and
20 that therefore physicians are bound to disagree over the
21 propriety of various treatments.").

22 Even medical approaches that are in the minority can be
23 considered within the standard of care. See 1 Am. Law Med. Malp.
24 § 3:3 ("What is custom and practice in the medical profession is
25 usually a reliable measure of due care. However, that is not
26 always the case.") (citing Texas & P. Ry. Co. v. Behymer, 189
27 U.S. 468, 470 (1903)). It could even be considered a violation
28 of the standard of care to continue using a long-established

1 treatment if a doctor failed to remain informed of advances in
2 medical knowledge. See id. ("The standard of care clearly
3 requires a doctor to keep up to date and abreast of changes.").⁷

4 As the Supreme Court has stated, states have "wide
5 discretion to [regulate] areas where there is medical and
6 scientific uncertainty." See Gonzales, 550 U.S. at 163. COVID-
7 19 is far from the first medical topic to prompt controversy and
8 serious disagreement among doctors and scientists. See, e.g.,
9 Conant, 309 F.3d at 643 (Kozinski, J., concurring) (describing
10 the "genuine difference of expert opinion on the subject [of
11 medical marijuana], with significant scientific and anecdotal
12 evidence supporting both points of view"); Caroline Lowry,
13 Intersex in 2018: Evaluating the Limitations of Informed Consent
14 in Medical Malpractice Claims As A Vehicle for Gender Justice, 52
15 Colum. J.L. & Soc. Probs. 321, 339 (2019) ("[t]he standard of
16 care for treating intersex individuals is controversial and ever-
17 changing" due in part to "sparse and incomplete" research on the
18 topic); Katherine Goodman, Prosecution of Physicians As Drug
19 Traffickers: The United States' Failed Protection of Legitimate
20 Opioid Prescription Under the Controlled Substances Act and South

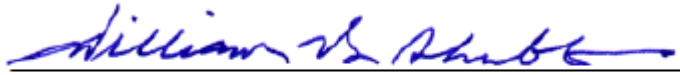
21
22 ⁷ Indeed, California law recognizes that medical science
23 is frequently changing and can offer worthwhile treatments that
24 are not broadly accepted. The California Right to Try Act, Cal.
25 Health & Safety Code § 111548, provides that a patient with a
26 life-threatening disease who has considered all available FDA-
27 approved treatment options and is unable to participate in an
28 applicable clinical trial has the right to undergo an
"investigational" treatment recommended by his physician, see id.
§ 111548.1(b). A physician is immune from Board discipline for
prescribing investigational treatments under those circumstances,
when carried out in accordance with the procedural protocol
established by the relevant Board. See id. § 111548.3(a).

1 Australia's Alternative Regulatory Approach, 47 Colum. J.
2 Transnat'l L. 210, 226-27 (2008) ("physicians widely disagree
3 about the propriety of administering narcotics for short-term
4 pain or to addicts, and there is little agreement about the
5 addiction risks that narcotics present" and "the maximum
6 thresholds for high-dose opioid therapy"). It would be absurd to
7 conclude that the State forfeits its broad authority to regulate
8 the practice of medicine whenever such disagreement is present.

9 For the court to conclude that no standard of care
10 exists in the realm of COVID-19 would create an unprecedented
11 exception to the long-established regulatory paradigm governing
12 medical professionals. Such a conclusion would also functionally
13 exempt doctors from both private malpractice actions and
14 disciplinary proceedings under section 2234(c) whenever they
15 provide care in connection with that disease, placing the public
16 at risk of harm without recourse or adequate oversight.

17 Because plaintiffs have failed to establish a
18 likelihood of success on the merits of their First Amendment
19 challenge to California Business & Professions Code § 2234, IT IS
20 HEREBY ORDERED that plaintiffs' motion for preliminary injunction
21 (Docket No. 14) be, and the same hereby is, DENIED.

22 Dated: April 22, 2024

23 
24 **WILLIAM B. SHUBB**
25 **UNITED STATES DISTRICT JUDGE**
26
27
28